

**COMMONWEALTH OF KENTUCKY**  
**DEPARTMENT OF WORKERS CLAIMS**  
**Before Arbitrator \_\_\_\_\_**  
**Claim Number \_\_\_\_\_**  
**NOTICE OF CLAIM DENIAL OR ACCEPTANCE**

Filed:

Do Not Write In This Space

\_\_\_\_\_  
**Plaintiff/Employee**

**VS.**

\_\_\_\_\_  
**Defendant/Employer**

Comes the defendant, \_\_\_\_\_, as insured by \_\_\_\_\_, and in response to the Application for Resolution of Claim, states as follows:

- \_\_\_\_\_ 1. This claim is accepted as compensable in its entirety. A settlement agreement will be filed. (Note: if claim is accepted, do not complete paragraphs 2 - 7).
- \_\_\_\_\_ 2. This claim is accepted as compensable, but there is a dispute concerning the amount of compensation owed to the plaintiff.
- \_\_\_\_\_ 3. This claim is denied for the following reasons:
- \_\_\_\_\_ (a) Plaintiff's last injurious exposure to the risks of the occupational disease alleged did not occur in the employment of this defendant.  
Explain:
- \_\_\_\_\_ (b) The plaintiff did not give due and timely notice to employer of the alleged occupational disease.  
Explain:
- \_\_\_\_\_ (c) The claim is barred by limitations.  
Explain:
- \_\_\_\_\_ (d) Plaintiff has not contracted the occupational disease alleged.  
Explain:
- \_\_\_\_\_ Other reason for denial.  
Explain:
4. The plaintiff's average weekly wage at the time of the alleged exposure was \$\_\_\_\_\_. Completed AWW-1 to support this calculation is attached.
5. The following witnesses may present testimony relevant to denial of this claim.
- 1.
  - 2.
  - 3.
  - 4.

6. The following are admitted by the employer:

Yes No

\_\_\_\_\_ This claim is covered by the Workers Compensation Act.

\_\_\_\_\_ Plaintiff was an employee of this defendant on the date alleged in the Application for Resolution of Claim.

\_\_\_\_\_ Plaintiff was exposed to the hazards of the disease during employment by more than one employer.

\_\_\_\_\_ Plaintiff has returned to work for this employer and is earning \$\_\_\_\_\_ per week.

7. For alleged occupational diseases other than coal workers' pneumoconiosis, describe in detail the physical requirements of plaintiff's job on the alleged date of last exposure. If an official job description exists, a copy must be attached.

8. The following persons have gathered information for completion of this form.

For the employer:

\_\_\_\_\_  
Name Title  
\_\_\_\_\_  
Address Street  
\_\_\_\_\_  
City State Zip Code  
( )  
Telephone Number

For the insurance carrier:

\_\_\_\_\_  
Name Title  
\_\_\_\_\_  
Address Street  
\_\_\_\_\_  
City State Zip Code  
( )  
Telephone Number

Being duly sworn, the undersigned states that the statements in this form are true and correct to the best of my knowledge and belief. This the \_\_\_\_\_ day of \_\_\_\_\_, 199\_\_.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Title

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone Number

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 199\_\_

My commission expires: \_\_\_\_\_

County: \_\_\_\_\_

\_\_\_\_\_  
Notary Public

Prepared and submitted by:

\_\_\_\_\_  
Representative/Title

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone Number